DCH/LOS-501 (12/04)

Michigan Department of Community Health
Board of Osteopathic Medicine and Surgery
P.O. Box 30670
Lansing, Michigan 48909
(517) 335-0918
www.michigan.gov/healthlicense

OSTEOPATHIC MEDICINE AND SURGERY LICENSURE INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Osteopathic Medicine and Surgery. Questions regarding your application can be directed to the Board of Osteopathic Medicine and Surgery at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time. Applications submitted without the required licensing fee, applicant's signature and date will be returned.

LICENSURE BY EXAMINATION – The following must be received in the Board office:

1. Completed application and required fee(s). An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid. The separate controlled substance application and fee must be submitted if you will be prescribing, dispensing, manufacturing or distributing any controlled substances in Michigan.

2. Passing scores on Parts 1, 2, and 3 of the National Board examination submitted directly to this office by the National Board of Osteopathic Medical Examiners.

3. Final, official transcripts, requested by you and sent directly to this office from your school, showing the degree earned and the date conferred.

4. Verification of the completion of one year of AOA approved post-graduate internship training that is forwarded directly to this office from the training hospital must be on the Certification of Internship form (attached). **If the internship you completed was in an allopathic facility, you must contact the AOA to request approval of the program. If approved, the AOA must submit a letter directly to this office verifying the program's approval. If the osteopathic internship you completed was prior to 1988, you must contact the AOA and request a letter from the AOA be submitted directly to this office verifying the program's approval.**

5. Verification of licensure from each state where you hold or have ever held a license. You are responsible for completing part 1 of the enclosed Verification of Licensure form and submitting it to each state where you hold or have ever held a license to practice osteopathic medicine and surgery. The completed form must be submitted to the Michigan board directly from the state that is providing the verification. Most licensing agencies charge a fee for this service. The Verification of Licensure form may be duplicated if necessary.

LICENSURE BY ENDORSEMENT - The following must be received in the Board office:

1. Completed application and required fee(s). An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid. The separate controlled substance application and fee must be submitted if you will be prescribing, dispensing, manufacturing or distributing any controlled substances in Michigan.

2. Applicants licensed in another state less than five years, must arrange for passing scores on Parts 1, 2 and 3 of the National Board examination to be sent directly to this office by the National Board of Osteopathic Medical Examiners. If you have been licensed in another

3. Final, official transcripts, requested by you and sent directly to this office from your school, showing the degree earned and the date conferred.

4. Verification of the completion of one year of AOA approved post-graduate internship training that is forwarded directly to this office from the training hospital must be on the Certification of Internship form (attached). **If the internship you completed was in an allopathic facility, you must contact the AOA to request approval of the program. If approved, the AOA must submit a letter directly to this office verifying the program's approval. If the osteopathic internship you completed was prior to 1988, you must contact the AOA and request a letter from the AOA be submitted directly to this office verifying the program's approval.**

5. Verification of licensure from each state where you hold or have ever held a license. You are responsible for completing part 1 of the enclosed Verification of Licensure form and submitting it to each state where you hold or have ever held a license to practice osteopathic medicine and surgery. The completed form must be submitted to the Michigan board directly from the state that is providing the verification. Most licensing agencies charge a fee for this service. The Verification of Licensure form may be duplicated if necessary.

The Michigan Board of Osteopathic Medicine and Surgery now accepts the Federation Credentials Verification Service (FCVS). The Federation of State Medical Boards (FSMB) makes this service available to applicants. The FCVS verifies a physician's basic credentials with primary sources. Those credentials include medical education, post-graduate training, examination history, and board action history.

Applicants for osteopathic medical licensure in Michigan may use the FCVS in lieu of separate verification of the above credentials from their primary source, as outlined above. **Please note, however, that the use of the FCVS is strictly voluntary on the part of the applicant and that Michigan Board of Osteopathic Medicine and Surgery might still request additional information from the applicant during the application review process.**

If you are interested in receiving more information or have any questions regarding this service, please contact the FSMB at (817) 868-5000.

GENERAL INFORMATION

1. NAME AND/OR ADDRESS CHANGES: If your name and/or address changes please notify the Board of Osteopathic Medicine and Surgery in writing. To change a name or address, you can download the Data Change/Duplicate License Request Form from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.

2. REFUND POLICY: If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Osteopathic Medicine and Surgery in writing to request a refund.

ORIGINAL LICENSES ARE VALID FOR ONE YEAR OR LESS; SUBSEQUENT RENEWALS ARE FOR A THREE-YEAR PERIOD.

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CERTIFICATION OF INTERNSHIP

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

INSTRUCTIONS TO APPLICANT:

Complete Section I. Type or print your name exactly as it appears on your application. For completion of Section II, send this form to the Medical Director or Superintendent of the training hospital where you served your internship. This certification must be submitted directly to the Michigan Board of Osteopathic Medicine and Surgery by the Director of the training program.

SECTION I - APPLICANT INFORMATION

First Name	Middle Name	Last Name
Social Security Number		Date of Birth
Hospital Street Address		
City	State	ZIP Code
Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)	

Name of Hospital

Signature of Applicant	Date

Applicant: **Upon completion of Section I, send this form to the Medical Director or Superintendent of the training hospital where you served your internship for completion of Section II.**

Name

THIS SIDE TO BE COMPLETED BY THE MEDICAL DIRECTOR OR SUPERINTENDENT

SECTION II - CERTIFICATION OF INTERNSHIP

Please complete the following information. Return this completed certification directly to the Michigan Board of Osteopathic Medicine and Surgery at the address shown on the reverse side of this form.

Name of Hospital		
Street Address of Hospital		
City	State	Zip Code

Is this internship AOA approved?

☐ Yes ☐ No

I certify that _____
(Applicant's Name)

has completed one year of internship at the above named hospital beginning _____
(Month/Day/Year)

and ending _____.
(Month/Day/Year)

I certify that this internship is one year in duration; of a rotating type, with rotations in the organized departments of Medicine, Surgery, Obstetrics and Gynecology; and that this Hospital is currently approved for the training of interns by the American Osteopathic Association. I further certify that the above named physician has served an apportioned time in each of the named rotations and has satisfactorily performed his/her duties.

_____
Signature of Medical Director or Superintendent

_____ _____
Print or Type Name Date of Signature

_____ (S E A L)
Title

If hospital has no seal, please indicate

IMPORTANT: This certification may not be dated and submitted more than fifteen (15) days prior to the completion of a full year's internship.

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APPLICATION FOR LICENSURE

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, MI 48226 (Telephone 1-800-882-9539).

Board Use Only
License Number
Date of Licensure

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

☐ **License by Examination Fee: 150.00 71-5101-01**

☐ **License by Endorsement (Must Currently be Licensed in Another State) Fee: $150.00 71-5101-09**

Your check or money order drawn on a US financial institution and made payable to the STATE OF MICHIGAN must accompany this application. DO NOT SEND CASH. Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Daytime Phone Number
Street Address		
City	State	ZIP Code
All Previous Names and/or Birth Name Used (if applicable)		
Have you ever held a health professional license in Michigan? ☐ No ☐ Yes	Michigan Permanent I.D/License Number and Expiration Date	

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony?	☐ Yes	☐ No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?	☐ Yes	☐ No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	☐ Yes	☐ No
4. Have you been treated for substance abuse in the past 2 years?	☐ Yes	☐ No
5. Have you had 3 or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?	☐ Yes	☐ No
6. Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?	☐ Yes	☐ No
7. Have you ever had a federal or state health professional or controlled substance license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	☐ Yes	☐ No
8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified?	☐ Yes	☐ No

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

Name

9. Have you ever been denied the privilege of taking an examination by any state medical board? ☐ Yes ☐ No

10. Do you hold or have you held an osteopathic license or registration in any state(s)? If so, list each state, the license number, the date issued, and how the license was obtained (either endorsement or examination). DO NOT LIST TEMPORARY LICENSES. **You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.)** ☐ Yes ☐ No

State	License Number	Date of Issue	How Obtained (Endorsement or examination)

Provide a complete chronological record of your educational preparation. Attach additional sheets if necessary.

Name and address of Institution	Dates of Attendance From	To	Degree

Provide a description of your intern/residency training experience. Attach additional sheets if necessary.

Name and address of Hospital	Dates of Practice From	To	Program Title
Internship:			
Residency:			

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date

Michigan Department of Community Health
Board of Pharmacy
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

DCH/LPH-090 (01/05)

CONTROLLED SUBSTANCE LICENSE APPLICATION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who manufacturers, distributes, prescribes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended.

A separate controlled substance license is required for each business location from which you manufacture, distribute, or dispense controlled substances. If you only prescribe controlled substances at more than one location, you only need one controlled substance license.

Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration 431 Howard Street, Detroit, Michigan 48226 (telephone: 800-882-9539). The Michigan Board of Pharmacy is unable to answer questions about the federal licensing process.

Board Use Only
Date of Licensure
License Number

Type or Print Only

INSTRUCTIONS

1. CONTROLLED SUBSTANCE FEE: **Initial (first time) professional license or relicensure of your professional license - $85.00. If you already hold a professional license and your professional license expires in:**

0-12 months the fee is $85.00 (13757) **13-24 months the fee is $160.00 (23757)** **25-36 months the fee is $235.00 (33757)**

2. **M.D./D.O. Applicants: This application may not be used for physician methadone programs. Please request an application for the Physician Methadone Program.**

3. **Allow up to six weeks for your paper license to arrive.**

Your check or money order drawn on a U.S financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH**. Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name

THIS LICENSE VALID - ONLY AT THE FOLLOWING LOCATION

Street	Telephone Number

City	State	ZIP Code

TYPE OF PROFESSIONAL LICENSE

(Please Check One):

	Regular		Educational Limited
☐ 29 - 01 D.D.S. 71-5315	☐	or	☐
☐ 59 - 01 D.P.M. 71-5315	☐	or	☐
☐ 69 - 01 D.V.M. 71-5315	☐	or	☐
☐ 43 - 01 M.D. 71-5315	☐		
☐ 51 - 01 D.O. 71-5315	☐		
☐ 49 - 01 O.D. 71-5330	☐		
☐ 53 - 01 Pharmacy Store 71-5301	☐		
☐ 53 - 02 R.Ph. 71-5302	☐		
☐ 53 - 06 Manuf./Wholesaler 71-5306	☐		

STATUS:

1. **Have you ever had any health professional license limited, suspended, revoked, denied, or surrendered?**

☐ **Yes** ☐ **No**

If Yes, please explain on separate sheet.

2. **Is your current professional license limited as a result of Board disciplinary action?**

☐ **Yes** ☐ **No**

Michigan Permanent I.D. Number (as shown on your pocket card)	
Expiration Date of License	Social Security Number

I am applying for a controlled substance license in Michigan and certify that the statements and information above are true.

Signature	Date

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the American's with Disabilities Act, you may make your needs known to this agency.

DCH/HLD-001 (12/04)

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VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.

- ☐ Chiropractic
- ☐ Counseling
- ☐ Dentistry
- ☐ Marriage & Family Therapy
- ☐ Medicine
- ☐ Nursing
- ☐ Nursing Home Adm.
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Osteopathy
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Physician's Assistants
- ☐ Podiatry
- ☐ Psychology
- ☐ Sanitarians
- ☐ Social Work
- ☐ Veterinary

First Name	Middle Name	Last Name
Previous Names Used	**Date of Birth**	**U. S. Social Security Number**
State Board	**License Number**	**Date of Issue**

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State.
Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Type of License:	Original Issue Date	Expiration Date

Basis for Issuance of License:

☐ Examination - Please indicate type of exam (National, Regional, State, etc.) _____

☐ Endorsement - Please indicate name of state _____

License Status
☐ Current ☐ Lapsed ☐ Inactive

Has the applicant incurred any formal or informal actions in your State?
☐ No ☐ Yes - If Yes, Please attach certified copies of any actions.

Are formal or informal actions pending?
☐ No ☐ Yes

Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?
☐ No ☐ Yes

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

_____ _____
Signature **Date**

_____
Type or Print Name

(S E A L)

_____
Title

_____
Full Name of Licensing Board

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.